

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2012
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility</p>	F 157	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F157 Notify of Changes</u></p> <ol style="list-style-type: none"> 1. Resident #27 Physician was notified of the status of the healing pressure ulcer and new treatment order obtained on July 11, 2012. 2. All licensed nursing staff have been re-educated by the DON or designee on the Physician Notification policy and proper documentation of Physician notification. <u>To be completed by 8/10/12.</u> 3. The DON or designee will audit the Medical Records of 5 residents per week for 4 weeks, then 5 residents per month for 3 months for appropriate Physician 	8/10/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Mark de Winter**Administrator**8/3/12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>failed to notify the physician of a pressure ulcer for one (#27) of forty residents reviewed. The facility's failure resulted in a delay of physician treatment and harm to resident #27.</p> <p>The findings included:</p> <p>Resident #27 was admitted to the facility on March 7, 2012, with diagnoses including Peripheral Vascular Disease, Hypertension, Diabetes, and Dementia.</p> <p>Medical record review of the admission Minimum Data Set dated March 13, 2012, revealed the resident was at risk for developing pressure ulcers, had a stage 3 pressure ulcer (right heel), had a pressure reducing device for the bed, and required extensive assistance with bed mobility.</p> <p>Medical record review of the Wound/Skin Healing Record dated March 7, 2012, revealed, "...pre-admit...stage III...Right heel...0.5 x 0.9 x (less than) 0.2 (centimeters) ...wound bed brown (eschar)..."</p> <p>Medical record review of the Wound/Skin Healing Record dated April 3, 2012, revealed, "... (right heel) 0.4 x 0.7 x (less than) 0.2 (centimeters)...granulation tissue...slough...brown eschar..."</p> <p>Review of the next Weekly Wound Report dated April 17, 2012, revealed "... (right) lateral heel stage 3 0.4 x 0.7 (less than) 0.2 (centimeters)...loose eschar..."</p> <p>Medical record review of a skin assessment dated June 12, 2012, revealed, "...small area of</p>	F 157	<p>Notification of pressure ulcers and proper documentation.</p> <p>4. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, wound care nurse, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>		

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F 157	<p>Continued From page 2</p> <p>eschar to (right) heel...0.5 cm x 1 cm...no other skin breakdown noted..."</p> <p>Medical record review of a skin assessment dated July 6, 2012, revealed, "...healing stage (2) Rt (right) heel Stage (2) coccyx-noted 7/4/12 Reddened area around coccyx...Pressure sores are to be measured weekly by skin assessment nurse..."</p> <p>Medical record review revealed the next wound assessment dated July 11, 2012, revealed, "...eschar on (right heel) (1cm x 0.5 cm) 2 stage (2) wounds on coccyx (...3 cm x 1.5 cm) (...1.5 cm x 1 cm). Excoriated around wound bilat (bilateral) buttocks...Pressure sores are to be measured weekly by the skin assessment nurse..."</p> <p>Medical record review of the care plan dated March 15, 2012, revealed "...Perform complete skin assessment and record...1 time weekly starting 03/15/2012..."</p> <p>Review of the policy Stage III Pressure Ulcer, revealed, "...Cleanse area with normal saline or wound cleanser ...obtain physician order for one of the following...Pack wound with hydrogel and apply calcium alginate and cove dressing QD (everyday)...Pack wound with saline moist loose gauze and cover dressing BID (twice a day)...If indicated, Enzymatic debridement...to Necrotic area and apply telfa or saline moist loose gauze and cover dressing QD..."</p> <p>Medical record review of the Treatment Records (dated March 7, 2012, through March 31, 2012,) and April 1, 2012, through July 31, 2012, revealed a treatment for Betadine to Right Heel daily.</p>	F 157			

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ASBURY PLACE AT JOHNSON CITY

STREET ADDRESS, CITY, STATE, ZIP CODE

105 WEST MYRTLE AVENUE
JOHNSON CITY, TN 37604

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F 157	Continued From page 3 Medical record review revealed no physician's order on admission or after for any treatment for the stage III pressure ulcer to the right heel. Interview on July 11, 2012, at 10:40 a.m. with the DON, in the conference room, confirmed no physician's order had been obtained since the resident's admission on March 7, 2012, for treatment for the stage III pressure ulcer on the right heel. Observation and interview on July 11, 2012, at 5:30 p.m. with the resident's physician revealed two stage 2 pressure ulcers on the coccyx and a pressure ulcer on the right heel with eschar, as described by the physician. Interview with the physician on July 11, 2012, at 5:30 p.m., in the resident's room, confirmed the physician was unable to recall being notified of the stage III pressure ulcer to the right heel.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to assess for the use of a restraint for two (#106, #27) residents of forty residents reviewed.	F 221	<u>F221 Right to be Free from Physical Restraints</u> 1. Side rail assessments have been completed for Resident # 27 and # 106. Side rails were discontinued on July 23, 2012. 2. Side rail assessments have been completed for all other residents. <u>To be completed by 8/10/12.</u>	8/10/12

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F 221	<p>Continued From page 4</p> <p>The findings included:</p> <p>Resident #106 was admitted to the facility on May 14, 2012, with diagnoses including Mental Disorder, Osteoporosis, Vertebral Fracture, and Dementia.</p> <p>Medical record review of the Minimum Data Set dated May 20, 2012, revealed the resident required extensive assistance with one person physical assist for bed mobility and transfers.</p> <p>Review of the facility policy, Restraints-Physical, revealed "...A physical restraint is defined as any article, device, or garment that is used primarily to modify resident behavior by interfering with free movement...a physician's order is necessary for the use of a physical restraint...The need for restraints will be reevaluated at least quarterly to determine if continued restraint use is necessary to treat the resident's medical symptoms..."</p> <p>Observation on July 12, 2012, at 7:40 a.m., with Licensed Practical Nurse (LPN) #2, revealed the resident lying in a low bed with 1/4 siderails up located in the center of the bed to keep the resident from exiting the bed.</p> <p>Observation on July 16, 2012, at 1:30 p.m., with the Director of Nursing (DON) revealed the resident lying in a low bed with 1/4 siderails in the mid bed position.</p> <p>Medical record review revealed no restraint assessment for the use of the siderails.</p> <p>Interview on July 16, 2012, at 12:55 p.m. with the</p>	F 221	<p>3. All nursing staff have been re-educated by the DON or designee on the completion of side rail assessments and proper use of side rails. <u>To be completed by 8/10/12.</u></p> <p>4. The DON or designee will audit the Medical Records of 5 residents per week for 4 weeks, then 5 residents per month for 3 months for appropriate documentation of side rail assessments.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, wound care nurse, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>		

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F 221	Continued From page 5 DON, in the conference room, confirmed no assessment had been completed for the use of the siderails as a restraint. Resident #27 was admitted to the facility on March 7, 2012, with diagnoses including Peripheral Vascular Disease, Hypertension, Diabetes, and Dementia. Medical record review of the Minimum Data Set dated June 11, 2012, revealed the resident required extensive assistance with two person physical assist for bed mobility and total dependence with two person physical assist for transfers. Observation on July 11, 2012, at 7:45 a.m. revealed the resident lying in a low bed with 1/4 siderails up located in the center of the bed to keep the resident from exiting the bed. Medical record review revealed no restraint assessment for the use of the siderails. Interview on July 11, 2012, at 9:45 a.m. with the Assistant Director of Nursing, in the conference room, confirmed no assessment had been completed for the use of the siderails as a restraint.	F 221			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	<u>F281 Services provided meet professional standards</u>		

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F 281	<p>Continued From page 6</p> <p>by: Based on observation, medication record review, and interview, the facility failed to follow physician's orders for medication administration for one (#39) of forty sampled residents.</p> <p>The findings included:</p> <p>Resident #39 was admitted to the facility on February 22, 2012, with diagnoses including Congestive Heart Failure, Edema, and Coronary Artery Disease.</p> <p>Medical record review revealed an initial psychiatric consult was obtained on May 11, 2012, for depression and medication management. Further review revealed the resident had been having increasingly paranoid thoughts. Further review revealed the resident was "accusing staff of morbid acts such as killing the resident and taking out the resident's arteries."</p> <p>Medical record review revealed the resident was admitted to the hospital on May 18, 2012, and returned to the facility on May 21, 2012. Medical record review revealed a physician's order dated May 31, 2012, for Geodon (antipsychotic medication) 20 mg.(milligrams) to be given daily at 5:00 p.m.</p> <p>Medical record review of the physician's signed recapitulation (recap) orders for June 2012, revealed order for Geodon 20 mg. to be given at 5:00 p.m., pm (as necessary). Review of the medication administration record (MAR) for June 2012, revealed the resident only received the medication on June 6, 11, 13, & 14, 2012, (four</p>	F 281	<ol style="list-style-type: none"> 1. Medication Administration Record for Resident # 39 has been verified for accuracy. The MD was notified of the medication omission on July 11, 2012. 2. All Medication Administration Records for each resident have been verified for accuracy against Physician Orders. <u>To be completed by 7/31/12.</u> 3. The Medication Administration policy has been reviewed. The DON or designee has re-educated all licensed nursing staff on the Medication Administration policy and proper verification of the Medication Administration Record against Physician orders. <u>To be completed by 8/10/12.</u> 4. The DON or designee will conduct random audits of the Medication Administration Records for accuracy with Physician orders. Audits 	7/31/12	

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F 281	Continued From page 7 out of thirty days)	F 281	will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.	
	Review of the Psychiatric Consultation Follow Up dated June 25, 2012, revealed the resident continued to have delusions and paranoia and the recommendation was to continue Geodon 20 mg. daily at 5:00 p.m.		The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	
F 282 SS=D	Medical record review of the MAR for July 2012, revealed no documentation Geodon 20 mg. was given on July 3 or 4, 2012.	F 282		
	Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:46 p.m., confirmed the physician order sheet for June 2012, had been incorrectly transcribed and the resident was to have received Geodon 20 mg. daily (not prn). Further interview confirmed the resident had not received Geodon 20 mg. as ordered by the physician in June or July 2012.			
	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN		<u>F282 Services by qualified persons/per care plan</u>	
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		1. Foley catheter was changed on July 11, 2012 for Resident # 39.	
	This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow a care plan for indwelling catheter changes for one (#39) of forty residents reviewed.		2. All other residents with foley catheters were assessed to ensure proper foley care. <u>To be completed by 7/30/12.</u>	
	The findings included:			

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F 282	Continued From page 8 Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including urinary retention. Review of the resident's Care Plan dated May 24, 2012, revealed intervention of "change ...catheter and drainage bag every thirty days and prn (as necessary). Medical record review of hospital documentation revealed the resident's catheter was changed while in the hospital on May 21, 2012, with orders to change monthly. Medical record review revealed no documentation of a catheter change since readmission (fifty-one days). Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the resident's urinary catheter had not been changed since readmission on May 21, 2012.	F 282	3. The policy for Indwelling Foley Catheters was reviewed and revised. The DON or designee has re-educated the licensed nursing staff on the Indwelling Foley Catheter policy and proper foley care. <u>To be completed by 8/10/12.</u> 4. The DON or designee will conduct random audits of residents with indwelling foley catheters for proper foley care and adherence to current policy. Audits will be completed on 5 residents per week for 4 weeks, then 10 residents per month for 3 months.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for antipsychotic medication for	F 309	<u>F309 Provide care/services for highest well being</u> 1. Medication Administration Record for Resident # 17 has been verified for accuracy. The MD was notified of the medication omission on July 12, 2012.	

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F 309	<p>Continued From page 9 one (#17) of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #17 was admitted to the facility on July 13, 2011, with diagnoses including Chronic Airway Obstruction, Diabetes, Dementia with Depression, and Esophageal Reflux.</p> <p>Medical record review of the Minimum Data Set dated June 21, 2012, revealed the resident had severe cognitive impairment and required assistance with all activities of daily living.</p> <p>Medical record review revealed the resident was placed on Risperidone (antipsychotic) 0.5 mg. (milligrams) twice daily on July 13, 2011. Medical record review revealed a physician's order dated June 26, 2012, to decrease Risperidone to 0.25 mg. every morning and 0.25 mg. at bedtime.</p> <p>Review of the Medication Administration Record (MAR) for June, 2012 revealed no documentation the resident received Risperdal at bedtime on June 26, 27, 28, 29, and 30, 2012 (5 days) Further review revealed no documentation the resident received Risperdal in the morning June 27, 28, 29, and 30, 2012 (4 days).</p> <p>Review of the physician's recapitulation orders for July 2012, revealed an order for Risperdal 0.25 mg. every morning and 0.5 mg. at bedtime.</p> <p>Interview with the Director of Nursing (DON) in the hallway on July 12, 2012, at 9:45 a.m., confirmed the medication order had been transcribed incorrectly on the physician's recap orders and the resident was to receive Risperdal</p>	F 309	<p>2. All Medication Administration Records for each resident have been verified for accuracy against Physician Orders. <u>To be completed by 7/31/12.</u></p> <p>3. The Medication Administration policy has been reviewed. The DON or designee has re-educated all licensed nursing staff on the Medication Administration policy and proper verification of the Medication Administration Record against Physician orders. <u>To be completed by 8/10/12.</u></p> <p>4. The DON or designee will conduct random audits of the Medication Administration Records for accuracy with Physician orders. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p>	7/31/12

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F 309	Continued From page 10 0.25 mg. at bedtime. Medical record review of the MAR for July, 2012, revealed no documentation Risperdal 0.25 mg. was given at bedtime on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, or 11, 2012 (11 days). Observation on July 12, 2012, at 9:45 a.m., revealed the resident lying in bed with eyes closed. Interview with the DON in the hallway on July 12, 2012, at 9:45 a.m., confirmed the resident did not receive the bedtime dosage of Risperdal from June 26, through July 11, 2012, and no Risperdal 0.25 mg. morning dose was administered on June 27 - 30, 2012.	F 309	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, review of the Dietician Contract, observation, and interview, the facility failed to complete skin assessments, implement dietary recommendations, obtain physician orders for	F 314	<u>F314 Treatment/Svcs to prevent/heal pressure sores</u> 1. Skin Assessment was completed for Resident #27 on July 11, 2012. Wound Assessment was completed for Resident # 27. Resident's Physician and Dietician were notified of pressure ulcer on July 11, 2012. 2. Skin assessments were completed on all other residents by 7/15/12.	7/15/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2012
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>wound treatments, ensure the Registered Dietician assessed the resident, and ensure measures were in place to reduce pressure for resident #27. The facility also failed to ensure skin assessments were completed for resident #107. The facility's failure resulted in delayed treatments and harm to resident #27.</p> <p>The findings included:</p> <p>Resident #27 was admitted to the facility on March 7, 2012, with diagnoses including Peripheral Vascular Disease, Hypertension, Diabetes, and Dementia.</p> <p>Medical record review of the admission Minimum Data Set dated March 13, 2012, revealed the resident was at risk for developing pressure ulcers, had a stage 3 pressure ulcer (right heel), had a pressure reducing device for the bed, and required extensive assistance with bed mobility.</p> <p>Medical record review of the Wound/Skin Healing Record dated March 7, 2012, revealed, "...pre-admit...stage III (pressure ulcer)...Right heel...0.5 x 0.9 x (less than) 0.2 (centimeters) ...wound bed brown (eschar)..."</p> <p>Medical record review of the Wound/Skin Healing Record dated April 3, 2012, revealed, "... (right heel) 0.4 x 0.7 x (less than) 0.2 (centimeters)...granulation tissue...slough...brown eschar..."</p> <p>Review of the next Weekly Wound Report dated April 17, 2012 (two week time period from the last assessment) revealed "... (right) lateral heel stage 3 0.4 x 0.7 (less than) 0.2 (centimeters)...loose</p>	F 314	<p>3. Skin Assessment and Wound Care policies were reviewed and revised. The DON or designee has re-educated all licensed nursing staff on the Skin Assessment and Wound Care policies and procedures. <u>To be completed 8/10/12.</u></p> <p>4. The DON or designee will conduct random audits of the Skin Assessments and Wound Care assessments for completion and accuracy. Audits will be done on 5 residents per week for 4 weeks, then 5 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months</p>	8/10/12	

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 314	<p>Continued From page 12 eschar..."</p> <p>Medical record review of a skin assessment dated June 12, 2012, revealed, "...small area of eschar to (right) heel...0.5 cm x 1 cm...no other skin breakdown noted..."</p> <p>Medical record review of a skin assessment dated July 6, 2012, revealed, "...healing stage (2) (pressure ulcer) Rt (right) heel Stage (2) (pressure ulcer) coccyx-noted 7/4/12 Reddened area around coccyx...Pressure sores are to be measured weekly by skin assessment nurse..."</p> <p>Medical record review revealed the wound assessment completed on July 6, 2012 for the right heel pressure ulcer did not describe the size or color of the wound.</p> <p>Medical record review revealed the next wound assessment dated July 11, 2012, revealed, "...eschar on (right heel) (1cm x 0.5 cm) 2 stage (2) wounds on coccyx (...3 cm x 1.5 cm) (...1.5 cm x 1 cm) Excoriated around wound bilat (bilateral) buttocks...Pressure sores are to be measured weekly by the skin assessment nurse..."</p> <p>Medical record review of the care plan dated March 15, 2012, revealed "...Perform complete skin assessment and record...1 time weekly starting 03/15/2012..."</p> <p>Interview on July 11, 2012, at 2:15 p.m., with the Director of Nursing, in the conference room, confirmed the pressure ulcer on the coccyx identified on July 4, 2012 was found as a stage II sore. This resident was assessed on admission as hi-risk for pressure sores and required extensive assistance with bed mobility.</p>	F 314	and recommendations made as appropriate.		

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 314	<p>Continued From page 13</p> <p>Interview on July 16, 2012, at 1:30 p.m., with the Director of Nursing, in the hall, confirmed no wound assessment with a full description of the size and color had been completed for the pressure ulcer on the right heel the week of April 10, 2012, or from June 12, 2012 until July 11, 2012.</p> <p>Medical record review of a Dietary Note dated April 19, 2012, revealed, "...admitted 3/7/12...stage (3) (right) lateral heel, labs alb (albumin) 2.5 (reference range 3.2-4.6) on 3/3/12...Recommend Prosource liquid 1 oz (ounce) bid (twice a day)..."</p> <p>Medical record review of a High Risk Follow-Up form dated May 17, 2012, signed by the Registered Dietician, revealed "...unstageable decub (decubitus) (right) lateral heel...Recommend 1 oz liquid protein in 6-8 oz juice or other liquid bid (twice a day), Megace (appetite stimulant) 400mg (milligrams) bid..."</p> <p>Medical record review of a physician's order dated May 18, 2012, revealed "...1 oz liquid protein bid and Megace 400 mg bid..."</p> <p>Medical record review of the Medication Administration Record revealed Prosource (protein supplement to aid in healing) was started on May 21, 2012.</p> <p>Interview on July 11, 2012, at 2:15 p.m, with the DON, in the conference room, confirmed a delay (from April 19, 2012 until May 21, 2012; thirty-one day lapse) in starting the dietary recommendation of prosource.</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER

ASBURY PLACE AT JOHNSON CITY

STREET ADDRESS, CITY, STATE, ZIP CODE

108 WEST MYRTLE AVENUE

JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 14</p> <p>Review of the facility policy Stage III Pressure Ulcer, revealed, "...Cleanse area with normal saline or wound cleanser ...obtain physician order for one of the following...Pack wound with hydrogel and apply calcium alginate and cover dressing QD (everyday)...Pack wound with saline moist loose gauze and cover dressing BID (twice a day)...If indicated, Enzymatic debridement...to Necrotic area and apply telfa or saline moist loose gauze and cover dressing QD..."</p> <p>Medical record review of the Treatment Records dated March 7, 2012, through March 31, 2012, and April 1, 2012, through July 31, 2012, revealed a treatment of Betadine to Right Heel daily.</p> <p>Medical record review revealed no physician's order for the Betadine treatment or any physician ordered treatment since the resident's admission on March 7, 2012 for the stage III pressure ulcer to the right heel.</p> <p>Interview on July 11, 2012, at 10:40 a.m. with the DON, in the conference room, confirmed no physician's order had been obtained since the resident's admission on March 7, 2012, for treatment for the stage III pressure ulcer on the right heel.</p> <p>Observation and interview on July 11, 2012, at 5:30 p.m. with the resident's physician revealed two stage 2 pressure ulcers on the coccyx and a pressure ulcer on the right heel with eschar, as described by the physician. Interview with the physician, at this time confirmed the physician was unable to recall being notified of the stage III pressure ulcer to the resident's right heel.</p>	F 314		

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 314	<p>Continued From page 15</p> <p>Medical record review of the care plan reviewed on May 31, 2012, revealed "...Use pillows, pads, or wedges to reduce pressure on heels and pressure points..."</p> <p>Observation and interview on July 12, 2012, at 8:30 a.m. with Certified Nursing Assistant (CNA) #1 revealed the resident lying on the bed with the heels touching the mattress.</p> <p>Review of the Dietitian Contract revealed, "...All patients with pressure ulcers (stage 2 or more) will be assessed monthly by the registered dietitian..."</p> <p>Interview on July 16, 2012, at 10:45 a.m. in the conference room, with the Clinical Nutrition Director, confirmed the resident was not assessed by the Registered Dietitian until April 19, 2012, a delay in assessment of forty-three days from the resident's admittance on March 7, 2012, with a stage 3 pressure ulcer.</p> <p>Resident #107 was admitted to the facility on May 25, 2012, with diagnoses including Hypertension, Systemic Lupus Erythematosus, Urinary Retention, Depressive Disorder, Chronic Back Pain, and Raynaud's Syndrome.</p> <p>Medical record review revealed the resident was discharged to the hospital on June 29, 2012.</p> <p>Medical record review of the admission Minimum Data Set dated June 2, 2012, revealed the resident scored fourteen on the Brief Interview for Mental Status (BIMS) indicating the resident was independent with daily decision making, required</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 314	<p>Continued From page 16</p> <p>extensive assistance with bed mobility, transfers and walking, had a Stage I pressure ulcer, was at risk for development of pressure ulcers, and a pressure reducing device was used on the bed and chair.</p> <p>Medical record review of the (named skin) Risk Assessment Scale dated May 25, 2012, revealed a score of seventeen (17) and "...A score of 17 or below requires a weekly skin assessment/documentation in the medical record..."</p> <p>Medical record review of the Interim Care Plan dated May 25, 2012, revealed "...Resident is at risk for skin breakdown due to prednisone therapy, auto immune disease...Stg (stage) 1 coccyx...turn q (every) 2 hrs (hours) and PRN (as needed)..."</p> <p>Medical record review of the Admission Nursing Assessment dated May 25, 2012, revealed the resident had an excoriated sacrum.</p> <p>Medical record review of the skin assessment dated May 29, 2012, revealed the sacral area was red and a protective ointment was being applied daily.</p> <p>Medical record review revealed the next skin assessment was completed on June 8, 2012, and revealed "...coccyx area reddened with a pencil eraser sized area opened..."</p> <p>Interview on July 11, 2012, at 3:25 p.m., with the Assistant Director of Nursing (ADON), in the conference room revealed the resident was placed on a pressure reducing mattress upon</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 314	Continued From page 17 admission to the facility. Continued interview revealed the resident was to receive a weekly skin assessment and confirmed the resident did not receive a skin assessment from May 29, 2012, until June 8, 2012, a three day delay. Interview on July 12, 2012, at 12:25 p.m., with the physician, in the Administrator's office, revealed the physician had visited the resident on June 8, 2012, when the pressure ulcer increased to Stage II at the request of the nursing staff, the resident frequently rejected care, (turning and repositioning, and medications to assist with wound healing). Continued interview revealed the resident's pressure ulcer declined quickly and was unavoidable due to the resident's non-compliance.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to follow physician's orders for care and services for an indwelling catheter for one (#39) of forty sampled residents.	F 315	<u>F315 No Catheter, prevent UTI, restore bladder</u> 1. Foley catheter was changed on July 11, 2012 for Resident # 39. 2. All other residents with foley catheters were assessed to ensure proper foley care. <u>Completed by 7/30/12.</u> 3. The policy for Indwelling Foley Catheters was reviewed and revised. The DON or designee has re- educated the licensed nursing staff on the Indwelling Foley Catheter policy and proper foley care. <u>To be completed by 8/10/12.</u> 4. The DON or designee will conduct random audits of residents with indwelling foley catheters for proper foley care and adherence to current policy. Audits will		

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 315	Continued From page 18 The findings included: Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including Urinary Retention. Medical record review of physician's orders dated May 2012, revealed orders to change indwelling catheter every month. Medical record review revealed the resident was admitted to the hospital on May 18, 2012, and returned to the facility on May 21, 2012. Review of hospital documentation revealed the resident's catheter was changed on May 21, 2012 while in the hospital. Observation on July 11, 2012, at 9:55 a.m., revealed the resident sitting in a wheelchair in the therapy room. Observation revealed a urinary drainage bag connected to the wheelchair. Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the indwelling catheter had not been changed since readmission (fifty-one days).	F 315	be completed on 5 residents per week for 4 weeks, then 10 residents per month for 3 months. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced	F 319	<u>F319 NTX/SVC for</u> <u>Mental/Psychosocial difficulties</u> 1. Psychiatric services were obtained for Resident # 109 and # 106 on July 12, 2012. 2. All resident charts were reviewed to assure that all orders for Psychiatric services were completed per		

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NAME OF PROVIDER OR SUPPLIER

ASBURY PLACE AT JOHNSON CITY

STREET ADDRESS, CITY, STATE, ZIP CODE

**105 WEST MYRTLE AVENUE
JOHNSON CITY, TN 37604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	<p>Continued From page 19</p> <p>by: Based on medical record review, and interview, the facility failed to obtain psychiatric services timely for two (#109, #106) residents of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #109 was admitted to the facility on May 24, 2012, with diagnoses including Depression, Hypertension, and Senile Dementia.</p> <p>Medical record review of a physician's order dated May 25, 2012, revealed "...Psyche (psychiatric) consult...Dementia...Namenda (Anti-Alzheimer's) 5mg (milligrams)...twice daily..."</p> <p>Medical record review of a Psychiatric Note dated July 12, 2012, revealed "...behavioral findings...pt (patient) is frequently restless, often seen packing...belongings to go home...recommendation-would d/c (discontinue) namenda and aricept (Anti-Alzheimer's), as both drugs are at likely subtherapeutic doses, and therefore unlikely to be offering sig.(significant) benefit...would increase zoloft (Anti-Depressant) to 37.5mg q (every) am. would try to keep antihistamine use...to a minimum..."</p> <p>Interview on July 11, 2012, at 3:15 p.m. in the conference room, with the Social Service Director, confirmed psychiatric services had not seen the resident timely from May 25, 2012, (date of order) until July 12, 2012.</p>	F 319	<p>Physician orders. <u>Completed on 7/17/12.</u></p> <p>3. All orders for Psychiatric evaluations will be monitored by Social Services for timely completion.</p> <p>4. Social Services or designee will conduct random audits of Residents charts to assure orders for Psychiatric evaluations have been completed per Physician orders. Audits will be done on 5 residents per week for 4 weeks, then 5 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months</p>	7/17/12

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 106 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 319	Continued From page 20 Resident #106 was admitted to the facility on May 14, 2012, with diagnoses including Mental Disorder, Osteoporosis, and Dementia. Medical record review of a physician's order dated May 17, 2012, revealed "...psyche consult-impulsive behavior, dementia..." Medical record review of a Psychiatric Note dated July 12, 2012, revealed "...behavioral findings...pt (patient) is frequently anxious and restless, with poor sleep...recommendations...would d/c (discontinue) celexa (Anti-Depressant) and ambien (sleep), and start remeron (Anti-depressant) 7.5mg q hs (bedtime)-this will hopefully also aid appetite..." Interview on July 11, 2012, at 2:45 p.m., in the conference room, with the Social Service Director, confirmed psychiatric services had not seen the resident timely from May 17, 2012, (date of order) until July 12, 2012.	F 319	and recommendations made as appropriate.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety	F 323	<u>F323 Free of Accident Hazards/Supervision/Devices</u> 1. The bed pad alarm for Resident # 90 was immediately reconnected and checked to assure alarm was functioning appropriately. The side rails were assessed for proper placement for Resident #72 and side rail assessment was completed. The bed pad alarm for Resident # 106 was immediately reconnected on 7/12/12 and checked to assure alarm was functioning appropriately. The fall mats for Resident #106 were appropriately replaced at bedside at the time of the interview on July 16, 2012. 2. All alarms and fall mats were identified and checked		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2012
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 21</p> <p>devices were in place and functional for three (#90, #72, and #106) of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #90 was admitted to the facility on January 15, 2011, with diagnoses including Dementia with Behavior Disturbance, Congestive Heart Failure, Hypertension, and Atherosclerotic Cardiovascular Disease.</p> <p>Medical record review of the Minimum Data Set dated March 22, 2012, revealed the resident was independent with transfers and ambulation, scored a 9 on the Brief Interview for Mental Status (BIMS) indicating the resident had moderately impaired cognitive skills, and had experienced a fall without injury since the prior assessment.</p> <p>Medical record review of the Minimum Data Set dated June 18, 2012, revealed the resident required supervision with transfers and walking in room, scored a fifteen on the Brief Interview for Mental Status, indicating the resident was independent with daily decision making, and had no falls since the prior assessment.</p> <p>Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls.</p> <p>Medical record review of the Care Plan dated May 24, 2012, revealed "...is at risk for fall d/t (due to) unwillingness to wait for assistance while transferring...assist ...to wear non-slick footwear that fits...attempt to engage...in ADLs (activities of</p>	F 323	<p>for proper placement and functionality. <u>To be completed by 8/3/12.</u></p> <p>3. The DON or designee has re-educated the nursing staff on proper use of alarms. <u>To be completed by 8/10/12.</u></p> <p>4. The DON or designee will conduct random audits of resident alarms and fall mats for proper placement and functionality. Audits will be completed on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>	8/10/12	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 323	<p>Continued From page 22</p> <p>daily living) that improve strength, balance, and posture...Instruct on safety measures to reduce the risk of falls (posture, changing positions, use of handrails)...chair pad alarm, keep areas free of obstructions to reduce the risk of falls or injury...Keep nurse call light within easy reach. Instruct...to use call bell or call out for assistance...Keep personal items within easy reach, bed to be in lowest position with wheels locked...auto-lock brakes to wheelchair...bedpad alarm..."</p> <p>Medical record review of the nursing notes dated April 24, 2012, at 5:15 p.m., revealed "Resident found on bathroom floor with W/C (wheelchair) brakes unlocked. Resident c/o severe generalized back pain...FNP (Family Nurse Practitioner) notified and Lortab 5/500 (pain medication) now ordered to control pain also total spine x-ray ordered to determine that no injury was obtained...Intervention placed for q (every) 2 hr (hour) toileting schedule for resident to ensure safety upon BR (bathroom) visits..."</p> <p>Medical record review of an x-ray report of the portable spine dated April 24, 2012, revealed there were no acute fractures or subluxations identified.</p> <p>Review of the facility's Fall Investigation revealed when the fall occurred on April 24, 2012, the resident stated "I slid out of the chair" and the w/c (wheelchair) brakes were unlocked.</p> <p>Medical record review of a Therapy Screen dated April 25, 2012, revealed the resident had experienced a fall on April 24, 2012. Continued review of the Therapy Screen revealed</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>"...Resident observed in BR (bathroom) floor. No injury noted...brake repair as per discussion in Multidisciplinary Meeting..."</p> <p>Interview on July 11, 2012, at 12:50 p.m., with the Physical Therapy Assistant, in the conference room, revealed at the time of the resident's fall on April 24, 2012, the brakes on the resident's wheelchair were in need of repair.</p> <p>Interview on July 11, 2012, at 1:30 p.m., with the maintenance worker, in the conference room, confirmed the brakes on the right side of the resident's wheelchair, were loose and not locking and were repaired after the resident's fall on April 24, 2012.</p> <p>Observation on July 11, 2012, at 11:00 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident lying on the bed. Continued observation and interview revealed the cord to the bedpad alarm was lying on the floor beside the bed, with no alarm box attached to the resident's bed. Interview with LPN #1, at the time of the observation, confirmed the bedpad alarm was not functional.</p> <p>Resident #72 was admitted to the facility on April 16, 2009, with diagnoses including Dementia and Osteoporosis.</p> <p>Medical record review of the Fall Risk Assessment dated February 2, 2012, revealed the resident was at high risk for falls.</p> <p>Medical record review of the Minimum Data Set (MDS) dated May 16, 2012, revealed the resident scored a one on the Brief Interview for Mental</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>Status, indicating the resident had severely impaired cognitive skills, did not walk, was totally dependent for bed mobility and transfers, and had not fallen since the prior assessment.</p> <p>Medical record review of the Care Plan dated May 24, 2012, revealed "...History of falls...SR (side rails) (up) X (times) 2...mat @ (at) bedside while in bed..."</p> <p>Medical record review of the nursing notes dated June 18, 2012, at 7:30 p.m., revealed "Resident observed by CNA (Certified Nursing Assistant) sliding to floor from low bed to bedside mat...CNA exited room to place tray on meal cart & (and) when returned to room saw this occur...Assessed by nurse & lifted safely into bed. Intervention in place of educating CNA to replace bedrail when exiting room..."</p> <p>Review of the facility's fall investigation dated June 18, 2012, revealed the resident had no injuries related to the fall on June 18, 2012.</p> <p>Interview on July 12, 2012, at 8:30 a.m., with the Assistant Director of Nursing (ADON), in the conference room, revealed the ADON had investigated the fall the resident experienced on June 18, 2012, and confirmed the CNA had not raised the side rail at the time of the fall.</p> <p>Resident #106 was admitted to the facility on May 14, 2012, with diagnoses including Mental Disorder, Osteoporosis, Vertebral Fracture, Cerebrovascular Accident, and Dementia.</p> <p>Medical record review of the fall risk assessment</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>dated May 15, 2012, and June 25, 2012, revealed the resident was at high risk for falls.</p> <p>Medical record review of a physician's order dated May 14, 2012, revealed "...Bed pad alarm...fall risk..."</p> <p>Medical record review of the care plan reviewed on June 7, 2012, revealed "...bed pad alarm...mat (at) bedside while in bed..."</p> <p>Medical record review of the Nursing Note dated June 9, 2012, revealed "...Res. (resident) noted to be sitting on the floor beside...bed. SR (siderail) was down and bed alarm was in the drawer beside... bed on the (right) side...abrasion approx. (approximately) 3/4 (inches) long on...mid-back..."</p> <p>Medical record review of a Therapy Screen dated June 10, 2012, revealed "...Resident observed by nursing staff to be sliding off edge of bed onto (left) side onto floor..."</p> <p>Observation on July 12, 2012, at 7:40 a.m., with Licensed Practical Nurse (LPN) #2 revealed the resident lying on a low bed with mats on the floor and 1/4 siderails up in the mid bed position. Continued observation revealed the bed pressure pad alarm was not connected to the alarm box. Continued observation revealed the alarm box was sitting on top of the closet.</p> <p>Interview on July 12, 2012, at 9:45 a.m., in the conference room, with the Assistant Director of Nursing, confirmed the safety device was not in place at the time fall on June 9, 2012.</p> <p>The resident experienced no injuries.</p>	F 323			

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F 323	Continued From page 26	F 323			
F 325 SS=G	<p>Observation and interview with the Director of Nursing on June 16, 2012, at 1:30 p.m. revealed the resident lying in a low bed with 1/4 siderails up in the mid bed position, and confirmed the fall mats were not in place.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, review of the facility policy, observation, and interview, the facility failed to prevent a significant weight loss for one (#106) resident of forty residents reviewed.</p> <p>The facilities failure resulted in harm to resident #106.</p> <p>The findings included:</p> <p>Resident #106 was admitted to the facility on May 14, 2012, with diagnoses including Mental Disorder, Osteoporosis, Cerebral Vascular</p>	F 325	<p><u>F325 Maintain Nutritional Status unless unavoidable</u></p> <p>1. Order for mighty shake for Resident # 106 was received by Dietary department and placed on Resident's meal tray on 7/12/12.</p> <p>Registered Dietician was notified of weight loss for Resident # 106 on 7/16/12.</p> <p>Resident # 106 was placed on Hospice services on 7/16/12.</p> <p>2. Weight management policy was reviewed. Monthly / Weekly weights for all Residents were reviewed on 7/17/12 to assure appropriate interventions were in place for weight loss per policy.</p> <p>On 7/17/12, all residents Physicians orders were reviewed to ensure that proper supplements have been provided.</p>	7/17/12	

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F 325	<p>Continued From page 27 Accident, and Dementia.</p> <p>Medical record review of the Nutritional Assessment dated May 14, 2012, revealed, "...wt. (weight) 115 (pounds) IBW (Ideal Body Weight) 105 (pounds)...Diet Order: Regular..."</p> <p>Medical record review of the dietary note dated June 4, 2012, revealed "...Resident returned from the hospital, (6-2-12)...had a colonoscopy...appetite is fair...10 (pounds) (above)...IBW...mechanical soft diet...low residue, wt 115 (pounds)..."</p> <p>Review of the weight record revealed the resident weighed 111 pounds on June 6, 2012. Review of the weight record revealed the resident weighed 105 pounds on July 3, 2012, (5% weight loss in one month).</p> <p>Medical record review of a physician's order dated July 5, 2012, revealed, "...Mighty shakes with meals..."</p> <p>Review of the July, 2012, Medication Record revealed the mighty shakes were initialed as administered on July 6, 2012, through July 11, 2012, three times a day.</p> <p>Medical record review of a physician's order dated July 9, 2012, revealed "...diet texture (change) to mechanical soft solids/thin liquids..."</p> <p>Medical record review of a dietary note dated July 12, 2012, revealed "...weight on 8/7/12...111.0 (pounds)...Res. (resident) has had wt (weight) loss of 10 (pounds) since...returned from the hospital...Res. will receive super cereal for</p>	F 325	<p>3. The DON or designee has re-educated the nursing staff on Weight Management policies and procedures. <u>To be completed by 8/10/12.</u></p> <p>4. The DON or designee will conduct random audits of resident's charts that have experienced weight loss to ensure that Dietician has been appropriately notified. Audits will be completed on 5 residents per week for 4 weeks, then 5 residents per month for 3 months.</p> <p>The DON or designee will conduct random audits for Residents with dietary supplements to ensure delivery per Physician order. Audits will be completed on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator,</p>	8/10/12

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 165 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
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F 325	<p>Continued From page 28</p> <p>breakfast (and) shake tid (three times a day) for extra cal's (calories) (and) pro. (protein) as a precaution for further wt. loss..."</p> <p>Medical record review of a physician's order dated July 13, 2012, revealed " ...Megace (appetite stimulant) 40mg (milligrams) po (by mouth) q (every) day ...Restorative feeding/dining (at) breakfast (and) lunch ..."</p> <p>Review of the facility policy, Weight Change, revealed, " ...all residents with a significant weight change will be assessed ...Where indicated residents will be provided with fortified foods with increased calorie and/or protein, house supplements or placed on the Medical Nutrition Therapy Program..."</p> <p>Observation on July 12, 2012, at 8:30 a.m. revealed the breakfast tray was delivered to the resident with 2% milk, juice, oatmeal, bacon, toast, and egg. Further observation revealed no mighty shake on the tray.</p> <p>Observation and interview on July 12, 2012, at 8:45 a.m., with Licensed Practical Nurse (LPN) #2 confirmed no mighty shake on the breakfast tray or on the meal ticket. Further observation revealed the Certified Nursing Assistant feeding the resident, and the resident drank approximately 1/2 of the milk, juice and ate a few bites of oatmeal.</p> <p>Interview on July 12, 2012, at 8:50 a.m., at the Nursing Station, with the Clinical Nutrition Director confirmed the dietary department did not receive the order for the mighty shakes, and if the order had been received the mighty shake would be</p>	F 325	<p>Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>		

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F 325	<p>Continued From page 29 noted on the meal ticket.</p> <p>Interview on July 12, 2012, at 9:00 a.m. in the conference room, with the Food Service Director confirmed the dietary department had not received the order for the mighty shakes.</p> <p>Interview on July 12, 2012, at 1:40 p.m., in the conference room, with LPN #3, confirmed the mighty shake was initialed as administered on July 6, 7, 9, 10, and 11, 2012, at 8:00 a.m., and 12:00 noon, however LPN #3 confirmed did not visualize the mighty shake on the resident's tray.</p> <p>Review of the weight record revealed the resident weighed 96 pounds on July 13, 2012. (9 pound loss in 10 days)</p> <p>Interview on July 16, 2012, at 2:00 p.m., in the conference room, with the Food Service Director, confirmed the Registered Dietician had not assessed the resident.</p> <p>Interview on July 16, 2012, at 2:25 p.m. with the Food Service Director, in the conference room, confirmed the Registered Dietician had not been notified when the resident had the 5% weight loss.</p> <p>Interview on July 16, 2012, at 2:45 p.m. in the conference room, with the Director of Nursing (DON), confirmed would expect the Registered Dietician to see the resident at the time of the 5% weight loss.</p>	F 325			
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from</p>	F 412			

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F 412	<p>Continued From page 30</p> <p>an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide routine dental services for one (#80) of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #80 was admitted to the facility on January 9, 2010, with diagnoses including Hypertension, Dysphagia, Fractured Hip, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 20, 2011, and the MDS dated May 2, 2012, revealed the resident had "...obvious or likely cavity or broken natural teeth..."</p> <p>Medical record review of the Care Plan dated December 1, 2011, February 16, 2012, and May 10, 2012, revealed "...has obvious or likely cavity or broken natural teeth...schedule dental evaluation; arrange for follow-up care as</p>	F 412	<p><u>F412 Routine/Emergency Dental Services in NFS</u></p> <ol style="list-style-type: none"> 1. Resident #80 will have dental evaluation completed by 8/10/12. Resident # 80 has been evaluated for tooth pain and no pain or weight loss noted at this time. 2. As of 7/23/12 all Care Plans for residents were audited to ensure no dental exams were omitted from resident's plan of care. 3. The DON or designee has in serviced the Interdisciplinary Team on communication to Social Services when outside 	7/23/12	

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F 412	<p>Continued From page 31 indicated..."</p> <p>Medical record review revealed no documentation the resident had received a dental evaluation.</p> <p>Observation and interview on July 12, 2012, at 12:10 p.m., revealed the resident seated in a wheelchair, in the resident's room, and the resident stated had several broken teeth.</p> <p>Interview on July 11, 2012, at 4:45 p.m., with the Social Worker, in the conference room, confirmed the resident had not had a dental evaluation since admission to the facility.</p>	F 412	<p>dental services are appropriate. <u>To be completed by 8/10/12.</u></p> <p>4. The DON or designee will conduct random care plan audits to ensure need for outside dental services are appropriately provided. Audits will be completed on 5 residents per week for 4 weeks, then 5 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>	8/10/12	